



PUBLIC HEALTH

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HEALTHIER WASHINGTON**

Health Professional Shortage Area Designation
Office of Community and Rural Health
March 2006

Presentation Outline

- Overview of Health Professional Shortage Area Designation Process
- Programs associated with HPSA status
- Roles and responsibilities in updating designations
- Information on trends in access to primary care
- Advertisement: Other OCRH programs

What are Health Professional Shortage Areas and Medically Underserved Areas/Populations (MUA/Ps)?

- Originally established by the Federal Bureau of Primary Health Care in the 1970's to prioritize location of National Health Service Corp (HPSA) and new community health clinics (MUA/P) to the areas of highest need
- Over time several other programs and reimbursement enhancements (currently over 35) have adopted these designations as a means to establish initial eligibility.
 - Programs the designation system was not designed for
 - And which may conflict



A Taxonomy of Shortage Area Designations

- Health Professional Shortage Area (HPSA)
 - Medical, Dental and Mental Health
 - Expire if not updated by October of the fourth year from designation date
 - Geographic designations – total primary care capacity relative to the entire population
 - Population designations – capacity available to serve specific population vs. a specific population (Low-Income, Migrant Workers)
- Medically Underserved Areas/Populations (MUA/P)
 - Primary Care Only
 - In perpetuity
 - Medically Underserved Area (MUA) – entire population
 - Medically Underserved Population (MUP) for example the Low – Income Population
 - Based on an index derived from Poverty Levels, Infant Mortality and/or Low Birth weight, percent elderly, and population to provider ratios
 - Very difficult to obtain in Washington
 - Lack of poverty concentration
 - IMR/LBW rates

Designation is an Administrative Process

- Designation governed by complex **federal** rules which dictate
 - What population data to use (Total, Low Income or Migrant)
 - How your organize HPSA boundaries
 - Census tract or county geography
 - Only one designation at a time
 - How to count providers
 - Some are excluded
 - What constitutes a shortage
 - Total (Geographic) ratio 3500:1
 - Population ratio (3000:1)
 - Closed practices are not considered
 - Availability of alternate sources of care
- Designation rules subject to change:
 - New designation methodology in the works since 1998 – may not come out
 - Interpretation and flexibility of applying existing rules – this has gotten tighter in the last 4 years
 - Data sets we are required to use
- OCRH does not recommend using designations as a systematic measure of access to health care or as a means of targeting resources

Health Professional Shortage Areas (HPSAs) and MUAs: Key Benefits

- Most important programs are:
 - National Health Service Corps
 - **STATE LOAN REPAYMENT DOES NOT REQUIRE A HPSA**
 - J-1 Visa Waivers (State of Washington)
 - Rural Health Clinic status
 - Medicare Bonus Payments
 - New Physician Scarcity Area Payments do not require a HPSA
 - Medicare Telemedicine Reimbursement
 - Safe Harbor for Stark II provisions re Physician Self-Referral
- Can enhance eligibility for certain grants
 - “Medically Underserved Areas”
- See <http://www.doh.wa.gov/hsqa/ocrh/HPSA/hpsa1.htm> for more details

Which one you have matters – read the small print

Program	Designation Type Required or Helpful	
	HPSA	MUA
New Federally Qualified Health Center	Any are helpful	Must have
New Rural Health Clinic	Any Primary Care*	Any*
J-1 Visa Waiver Program	Any Primary Care**	Whole County
HPSA Medicare Bonus Payments	Geographic Primary Care***	
Physician Scarcity Area Payments	Not Required	Not Required
National Health Service Corps	Provider specific**	
State Loan Repayment and Scholarship	Not Required	Not Required
<p>* Designation valid until December 31 of the third calendar year from date of federal approval</p> <p>** There are requirements for serving the designated population</p> <p>*** Must be listed on Noridian Medicare Website</p>		

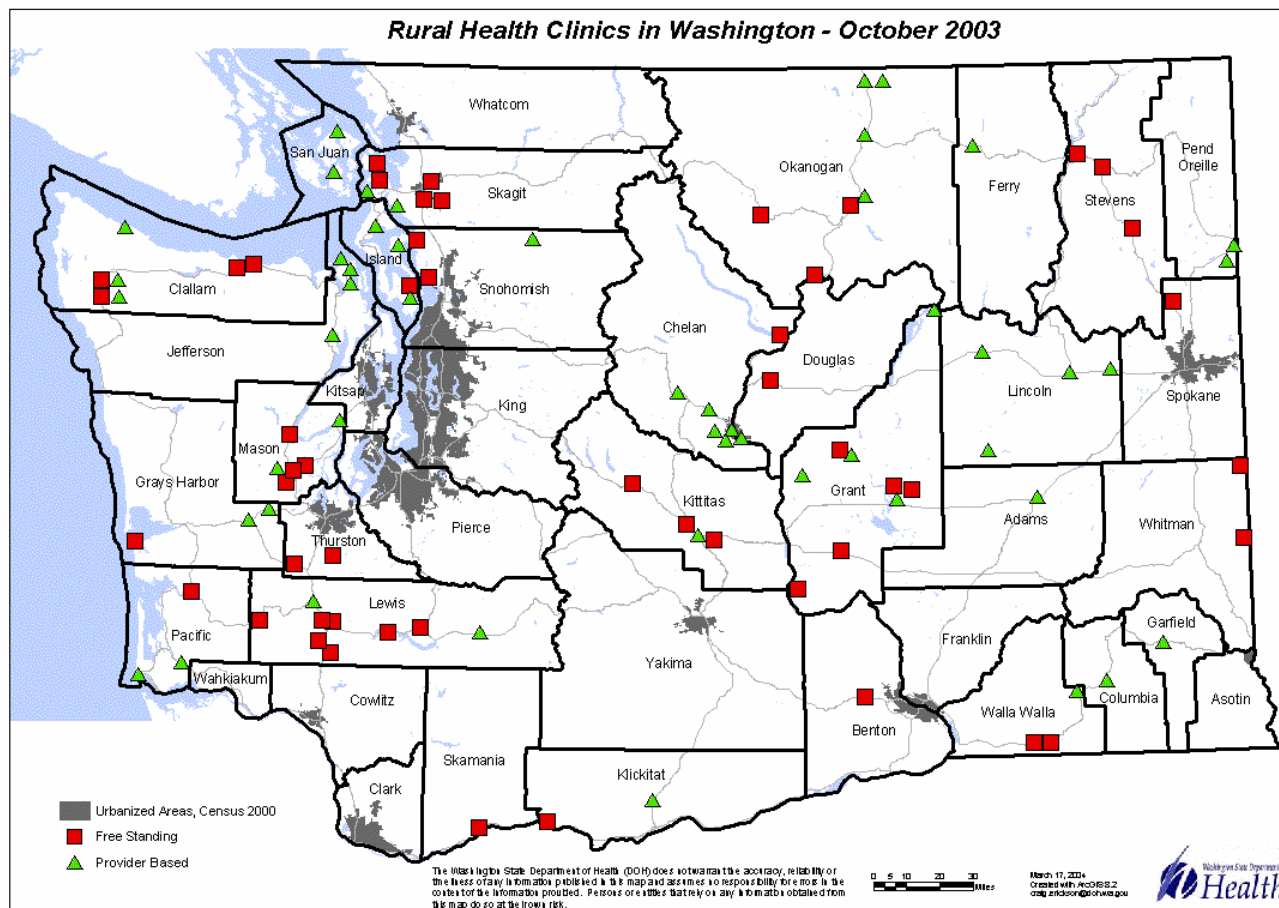
Rural Health Clinic Certification

- Enhanced Medicare and Medicaid Reimbursement
 - Prospective payment system based on hospital affiliation
- Federal certification by the Center for Medicare and Medicaid Services
- Facility located in “non-urbanized area” and HPSA
- Several additional conditions of participation
 - Policies and procedures
 - Employ a physician assistant, nurse practitioner or CNM 50% of the time
- Survey required (Department of Health – Facilities and Services Licensing Division)
 - For initial intake: Contact Laura Olexa, OCRH (360) 236 2811
 - For more info:
<http://www.doh.wa.gov/hsqa/ocrh/RHC/rhcMminpg.htm>

Rural Health Clinic: HPSA Issues

- Any type of HPSA establishes/maintains eligibility
- New Rural Health Clinic applications
 - Rules requiring current HPSA and non-urbanized area location for NEW RHC start have been “enforced since 2002 and are still in force.
 - Eligibility retained until 12/31 of the third calendar year from date of federal designation approval letter
 - Certification applies to location/facility – not to the entity. It is unlikely an RHC moving to a new location will be eligible if it is located in an urbanized area.
- Existing Rural Health Clinics
 - Any type of HPSA meets the shortage area requirement
 - HPSA location requirement for existing RHC is met if HPSA is in normal update cycle (4 years)
 - Loss of designation does not mean automatic loss of RHC status
 - Rules for decertifying existing RHCs in urbanized or currently undesignated areas are in limbo and may never get out
 - Existing clinics will keep current status for foreseeable future.
 - For overview of exceptions and issues or contact Vince Schueler at (360) 236-2806
 - Maintaining designations is insurance and is prudent

Currently 120 Rural Health Clinics



National Health Service Corps

- Medical Loan Repayment or Scholarships in exchange for 3+ year service commitment
- Primary Care Physicians, Nurse Practitioners, Physician Assistants (Also dental and mental health)
- Several additional requirements
 - Must serve the designated population (e.g. Low Income or Migrant Workers)
 - Posted Sliding Fee Scale discount schedule available at entire facility
- Competitive application process scored on degree of need
- Contact the Washington State Primary Care Office for more information on NHSC site requirements and competitiveness.
 - Mary Looker (360) 236 2808
 - Juno Whittaker (360) 236 2812

National Health Service Corp: HPSA Issues

- Type of HPSA influences
 - Which population the provider and site must serve
 - Need score (higher scores more competitive)
 - Score based on population to provider ratio (3500,4000,5000)
 - Health, poverty characteristics of the population
 - Distance to nearest care for the population
 - Maximum number of NHSC placed in an area (larger population in shortage means more providers could be placed)
- Automatic Facility Designation for NHSC
 - Available Rural Health Clinic, Community Health Centers and other practices willing to take all patients regardless of willingness pay
 - Not scored and therefore lower priority for placement
- In 2004 all sites applying for NHSC Loan Repayment were funded (this could change in the future)
- HPSA score is used for placing NHSC scholars – few areas of the state are currently eligible – but check with the Primary Care Office

J-1 Visa Waiver Program for International Medical Graduates (Conrad State 30 Program)

- Provides Visa Waivers for up to 30 International Medical Graduates willing to serve in Health Professional Shortage Areas each year
 - 75% of slots for family practice, OB/GYN, General internal medicine, pediatrics, and psychiatry
 - 25% of slots for general surgeons, diagnostic radiologists, and physicians with sub-specialties in family practice or internal medicine
- Location in any HPSA or Whole County MUA
 - Some exceptions for non-designated areas
- Some requirements to serve designated population
- Several additional requirements
- General Information: OCRH Washington State J-1 Program Information Line – (360) 236-2822

J-1 Visa Program: HPSA Issues

- Loss of designation does not affect providers under current obligation
 - Designation required to keep providers under extensions beyond 3 year obligation
 - Facility Designations meet the HPSA requirement
- Designation must be current for new J-1 Applicants
 - Current means the designation is listed as active by the Federal Bureau of Health Professions – Designations expire if no data is submitted to update the designation by October 31 of the fourth year after year of last designation/update approval
- Selection currently based on First Come – First Served
- No limits on the number of J-1s that can practice in any designated area, but
 - Only two primary care per practice location/program year
 - Only one specialist per practice location/program year
- Rules for expanding the number and nature of specialist slots and allowing some placements outside of HPSAs are under consideration – contact Jennell Prentice (360) 236-2814

Medicare Bonus Payments

- 10% bonus payments for most Medicare Part B procedures
 - Specialty and primary care – clinic and hospital settings
 - Not paid for services rendered in a Rural Health Clinic
 - Can be paid in addition to CAH payments (consult your accountant)
- Service must be provided in a Geographic Primary Care Shortage Area
- Area is not eligible until listed on the Fiscal Intermediary webpage – (now updated once a year)
- As of January 1, 2005 Paid automatically if ZIP Code completely in a county designation
 - See Noridian Website for list locations which are paid automatically
 - <http://www.noridianmedicare.com/provider/enrollment/hpsa.html>
 - If not on the “automatic payment list” you still may be eligible
 - Check to see if your area is listed as eligible
 - If yes you will need to submit bills with the appropriate modifier

Bonus Payments: What are Physician Scarcity Area Payments (PSAs)?

- New development authorized by the Medicare Modernization Act (Prescription Drug Bill)
 - System effective as of January 1, 2005
 - Does not require location in a HPSA
 - Separate designations for primary care and specialty care
 - Determined using national data sets (census and AMA data) applied to Medicare Primary Care Service Areas (established by Dartmouth).
 - Bonus goes to bottom 20% as determined by cumulative population
 - Current areas “fixed” until 2007 when they will be recalculated
 - It is possible for an area to have no PSA payments and no HPSA payments, PSA (5%) payments only, HPSA (10% for primary care) payments only, or both (15% for primary care, 5% for specialty care)



HPSA Primer

Three Primary Care HPSA Requirements:

1. A Rational Service Area

- Defined in census units only (federal law)
 - Nationwide system
- Geographic designations
 - Whole counties
 - But not if “too big” (>250,000) in urban areas
 - Multiple counties (Population center w/in 30 minutes travel time)
 - Sub-county areas or parts of multiple counties (Population center w/in 30 minutes travel time)
- Population designations
 - Whole or multiple counties
 - Sub-county areas must have similar racial and economic characteristics
 - Low-Income threshold > 30% below 200 % FPL

Three Primary Care HPSA Requirements

2. Ratio of Population to Physician Capacity in Rational Service Area Exceeds Federal Criteria

- Geographic (Total Population) designation threshold
 - Resident Civilian Population: Primary Care Physician Full-time Equivalencies > 3500:1
 - Threshold reduced to 3000:1 – if “high needs” area (low income population or other measures)
- Population (Low-Income or Migrant Worker) designation
 - Specific Population: Physician Capacity Serving the Population > 3000:1
- Requires comprehensive data on primary care physician capacity
 - Primary care includes Family Practice, OB/GYN, General Internal Medicine (GIM), Geriatric and Pediatric Physicians
 - Mid-levels not included in Federal definitions (but we survey them)
 - Providers excluded (NHSC, J-1, InHS, Urgent Care, Administrative)
 - Full-time Equivalent (FTE) Providers
 - Used to make apples to apples comparisons and adjust for hours of direct care
 - 1 FTE = 40 hours of direct patient care

Population Data Sources Determined by Federal Guidelines

- Resident Civilian Population and 200% Poverty Population (2000 Census)
- Homeless population if greater than Census 2000 counts (DCTED or local counts)
- Tourist population (local data adjusted for bed nights)
- Migrant Population (HRSA 2000 Migrant Enumeration adjusted for length of agricultural season)
- Total Population = County Population + additional homeless population + tourists (if applicable)
- Low Income Population = 200% FPL Population + Homeless
- May be able to use census estimates in 2-3 years

Three HPSA Requirements

3. Care not available in adjacent areas

- Geographic (Total Population)
 - Within 30 minute travel time (20-25 miles)
 - Total population ratio > 2000:1
 - Access barriers exist (geography, highways etc)
- Population Designation
 - 30 minute travel time (20-25 miles)
 - Low-Income or migrant Ratio
 - If over 20% > 100% FPL then can use transit travel times
 - Significantly different poverty/race/ethnicity
- Must consider capacity (<2000:1) regardless of whether providers are accepting patients

Roles and Responsibilities In Federal Designation System

- **Local Partners**
 - May initiate request for designation assistance
 - Assistance with data collection
 - Provide guidance on designation strategy
- **Office of Community and Rural Health/Primary Care Office**
 - Review/comment/approve on behalf of Governor
 - Prepares and monitors designation requests
 - Technical assistance on rules, methods, and data
 - Information on changes in designation status
- **Shortage Designation Branch/BHP/HRSA/USDHHS**
 - Sets rules and procedures
 - Reviews/approves designation requests
 - Notify states of decision

Making decisions on designation strategy

- More than one designation option possible
- Designation option affects program eligibility
- US DHHS only allows an area to have one designation at a time
- Trade-offs between
 - Competitiveness for National Health Service Corp Scholars
 - Medicare Bonus Payment
 - Areas eligible for J-1 Visa Waiver
- In MOST cases there is only one way to designate
- Our preference is for local direction
- If more than one designation option possible decision made in the following order
 - Stakeholder/community consensus
 - Local health jurisdiction recommendation
 - Office of Community and Rural Health reviews/decides as a last resort based on
 - Whether significant impact on financial viability of practices
 - Immediate effects on primary care recruitment (J-1 and NHSC)
 - Access for vulnerable populations

A New Partnership With Local Health Jurisdictions

- Initial contact/Local Health briefing (DOH)
- Stakeholder briefing (Local lead/DOH support)
 - Initial briefing re: designation and data collection
 - Enlisting support – participant outreach
- Data Collection (Local Lead/DOH Support)
- Analysis of designation options (DOH)
- Recommendation/direction on community designation strategy (Local Lead/DOH Back-up)
- Preparation and submission of designation requests (DOH)
- Notification of changes in designation status (DOH)
- Primary Care Access Assessment (Varies)
- Release of findings in community (Local Health)
- Aggregation into comparative studies (DOH)

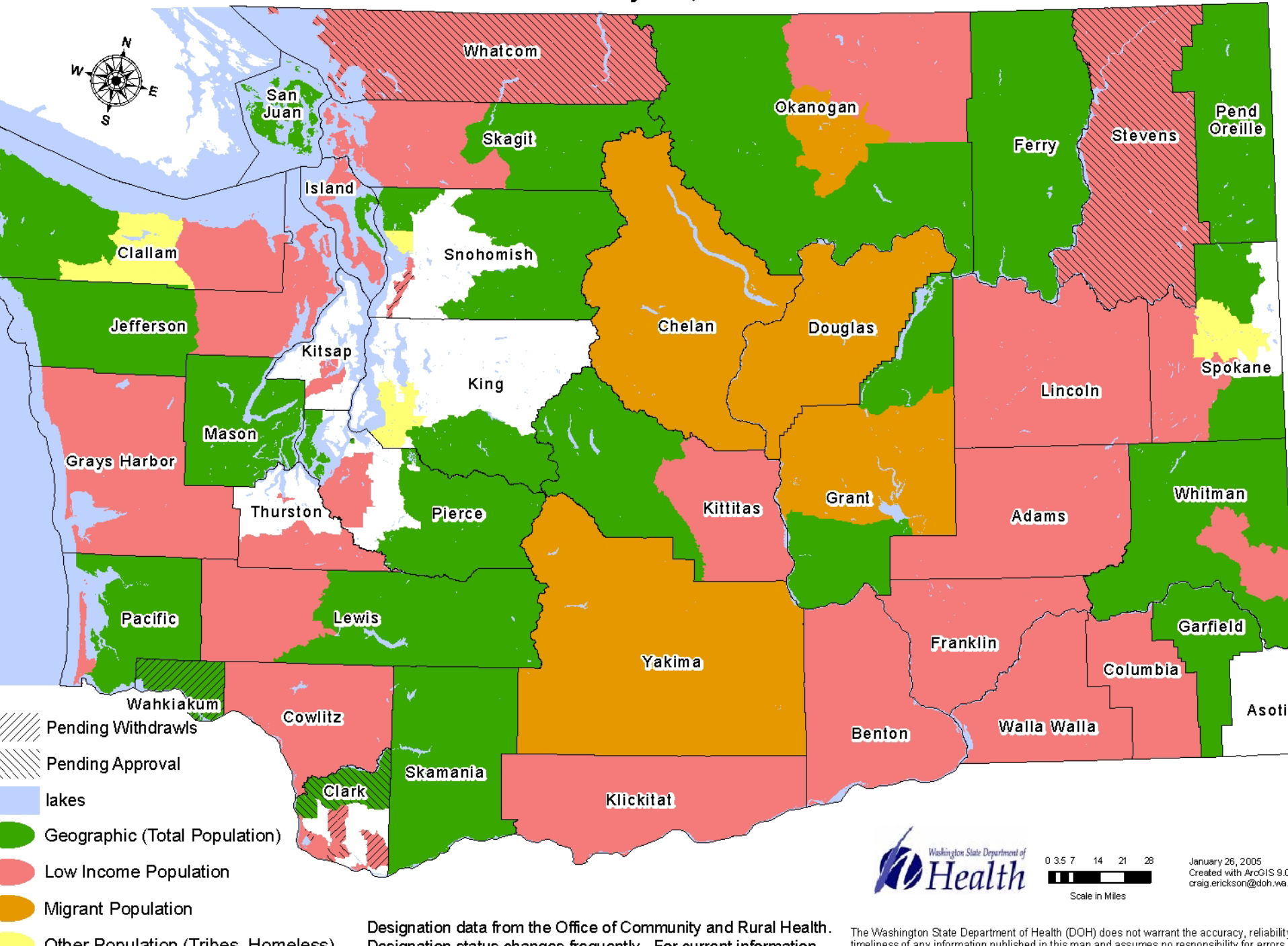
Who do I work with on HPSA / MUA Designation?

- OCRH Washington State Shortage Area HPSA Website
<http://www.doh.wa.gov/hsqa/ocrh/HPSA/hpsa1.htm>
- Laura Olexa (360) 236-2811
 - Current designation status
 - General information
 - Responding to provider surveys
- Vince Schueler (360) 236-2806
 - How can I get my area designated?
 - How do I make sure my concerns are addressed in the designation process?
 - Affects of changes in federal rules on eligibility for HPSA related programs
 - Concerns, complaints, and appeals

County Primary Care HPSA Assessment/Survey Schedule (subject to change)

2005	2006	2007	2008
Adams	Asotin	Chelan	Clallam (Forks)
Clallam (Port Angeles)	Benton/Franklin	Douglas	Clark
Columbia	Cowlitz	Grant	Grays Harbor
Ferry	Garfield	Pacific	Kitsap
Island (Camano)	Island (Whidbey)	Thurston	Okanogan
Klickitat	Jefferson	San Juan	Snohomish
Lincoln	Kittitas	Spokane	Stevens
Mason	Lewis	Yakima	Wahkiakum
Pend Oreille	Thurston		Whatcom
Pierce	Whitman		
Skamania	King		
Walla Walla			

January 26, 2005



0 3.5 7 14 21 28
Scale in Miles

January 26, 2005
Created with ArcGIS 9.0
craig.ericson@doh.wa

Designation data from the Office of Community and Rural Health.
Designation status changes frequently. For current information

The Washington State Department of Health (DOH) does not warrant the accuracy, reliability, timeliness of any information published in this map and assumes no responsibility for errors.

Access and Action: Recent developments encouraging OCRH to reinvent HPSA designation process

- New State Public Health standards include access to care issues
- Primary care is an essential service – a stable Primary Care Infrastructure is crucial for meeting other DOH and Local Health Missions of prevention and surveillance (LHJ's generally no longer in the role of provider of last resort).
- Increasing dependence on reimbursement enhancements and other federal and state support requiring health professional shortage area designations
 - Rural Health Clinics (105+)
 - Community and Migrant Health Centers (FQHC) (120+ sites)
 - Multiple designation options possible
 - Complex trade-offs between private practice and Community Clinic benefits
- Lack useful federal data on Medicare access issues
- Lack of comprehensive information across payers
- Concerns of provider shortages and physician flight
- Compliments OCRH mission of community development and encouraging local – coordinated responses to improve or maintain access to health care
- Lack of public awareness of health care financing
- Need for a good baseline to measure how the primary care capacity and availability is changing in response to increases in the insured, changes in reimbursement, and malpractice

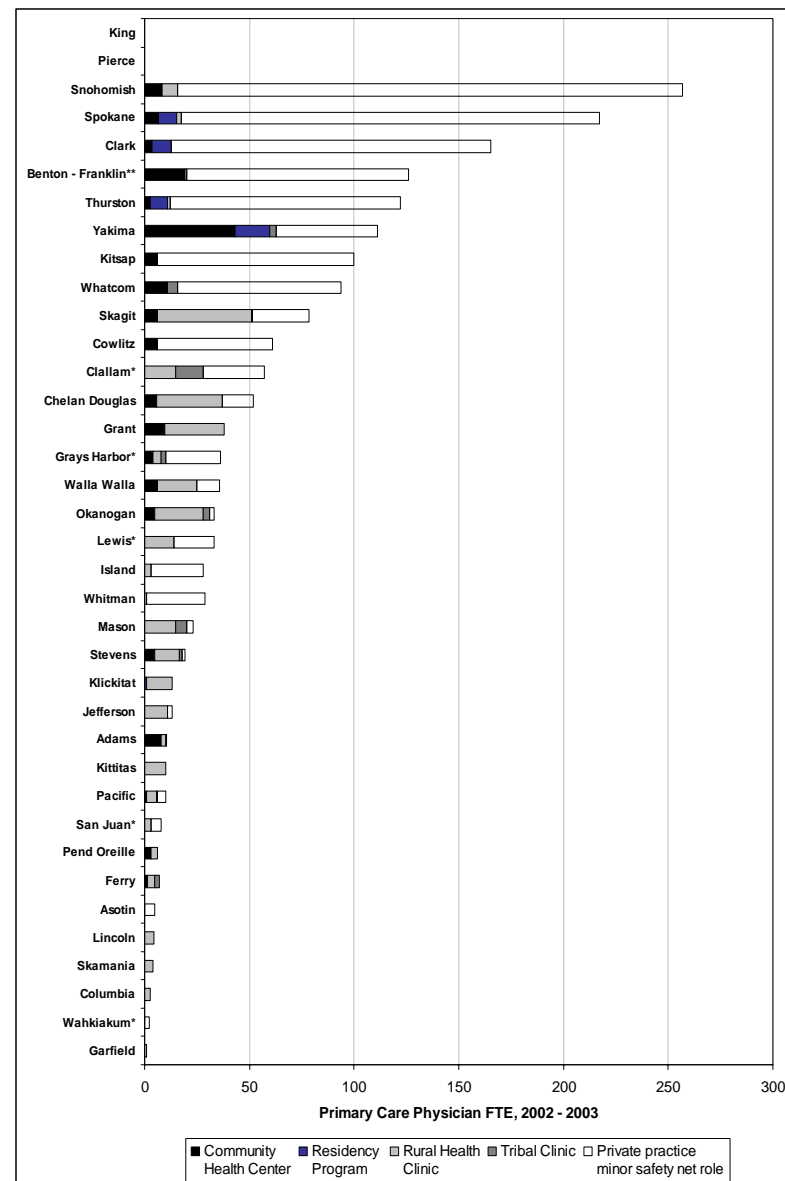
Doing Double Duty: Using HPSA Provider Inventory Data to Understand Access to Primary Care at the Local Level

- Physician Capacity Survey modified beyond the bare minimum needed for shortage area designation to include information on other payers
- Legitimate assessment
 - Up to date population data
 - Alternative geographic analysis
 - Elimination HPSA calculations
- Used to create detailed case studies – not a systematic statewide data set
 - Voluntary and subject to OCRH resources and local interest
 - Differences in instruments and collection methods (though it is becoming standardized)
 - Done over a rolling three – four year period
- Use of data for Health Professional Shortage Area designation may introduce some downward bias in reporting (especially FTE and Medicaid shares)
- But it is also very comprehensive and suggests important patterns and trends

Some Important Trends

- Primary care capacity in urban areas (especially in private practices) appears to be eroding slowly while it is increasing somewhat in rural areas
 - Long-term trends in primary care capacity – residency #s are much less promising
- Capacity for existing patients is not at the crisis level – but many counties are showing signs of stress
 - Medicare capacity appears reasonable
 - Low income capacity is worse but not dramatically so (this may be changing)
 - What we don't measure well is access for the working or near poor
- Access for existing patients is not dramatically worse in rural areas
 - There are specific areas with access concern
 - Access in large rural areas may be better than in some urban areas
- The most severe access issues are on the rural urban fringe
- Access for new publicly supported patients (Medicare, Medicaid and BHP) is worse in urban than rural areas in many cases dramatically so
 - The majority and some cases almost all private practices are closed to new public patients in sum urban counties
- The “Safety Net” in the state is not distributed evenly. Relationship between safety net strength and provider acceptance

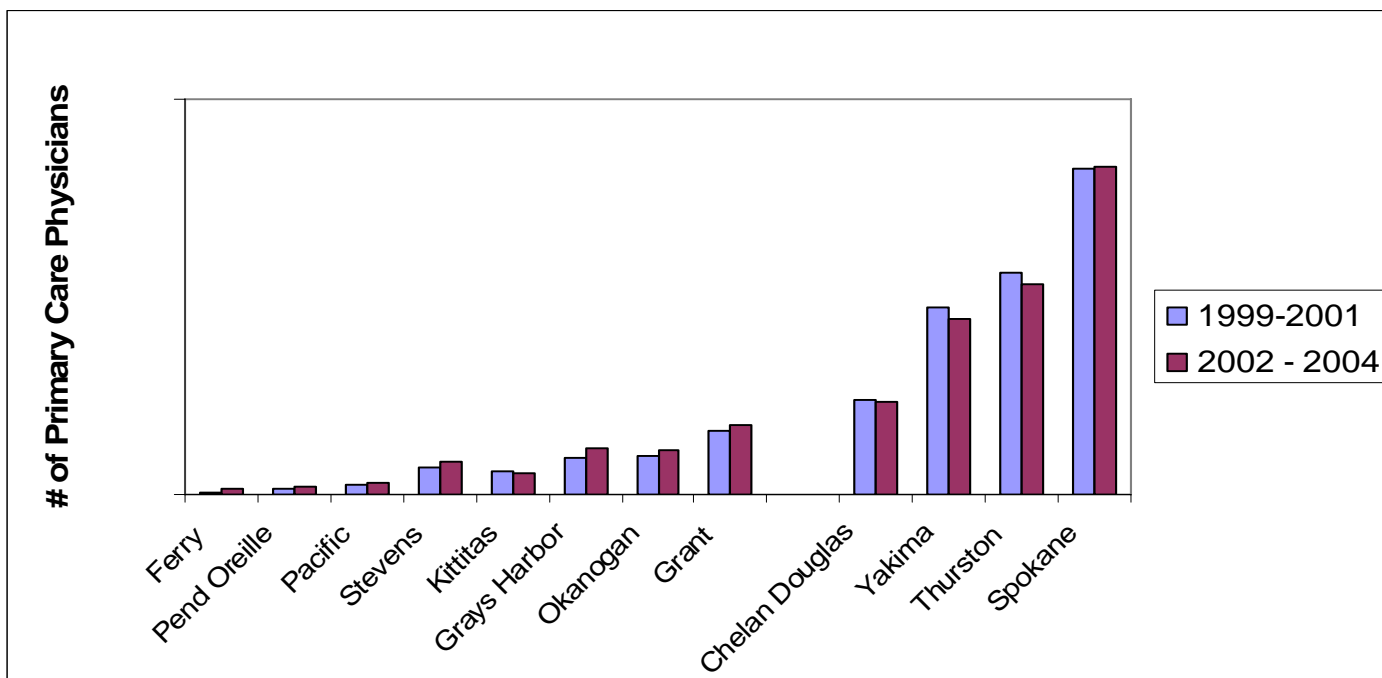
- Primary Care and Safety Net Capacity by County, 2003
 - **Core** safety net:
 - CMHC + Free Clinic
 - Mandate to serve all patients
 - Impact much greater than capacity – especially for serving the uninsured.
 - **Auxiliary** safety net:
 - Tribal clinics, residency programs, and rural health clinics
 - More likely than private practices but less likely than the core to take public patients
 - Very limited ability to serve uninsured
- State wide patterns
 - Counties with very weak safety nets with very large underserved populations
 - Auxiliary safety net typically stronger in rural counties
 - Rural providers more likely to accept public patients than urban providers



Primary care physician capacity is stagnant or eroding...

- The number of licensed physicians has been increasing steadily, BUT
- In most counties where a year to year comparison was possible the total number and/or FTE of direct patient care have declined or have remained unchanged
- Slow erosion and not a massive flight
- Specialty care may be different
- The recent exception being rural areas

Where data is available: Urban Primary Care Capacity stagnant or eroding – some gains in rural areas



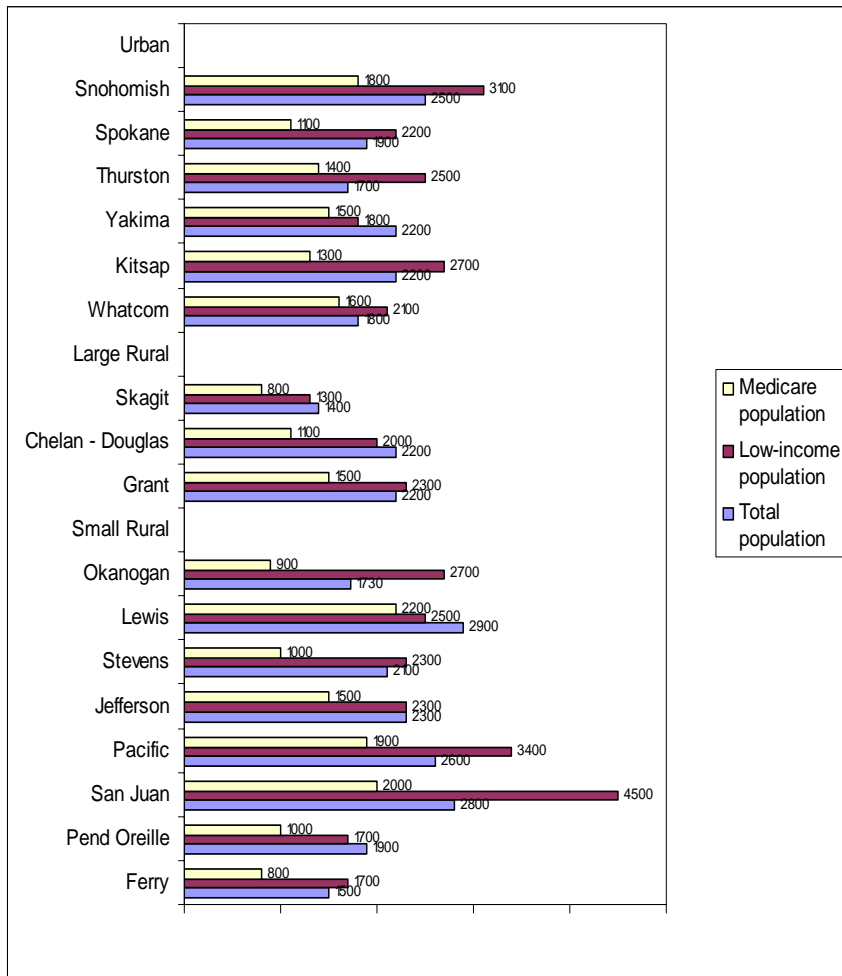
Why are rural counties doing better?

- Contributing causes
 - Rapid expansion of reimbursement enhancement programs have helped stabilized finances
 - Critical Access Hospital Program
 - Rural Health Clinic program
 - Targeted Recruitment and Retention Assistance from OCRH
 - Continued consolidation (affiliation with larger entities) of health care services increases stability
- Better does not mean everything is great
 - There are still areas with persistent provider shortages
 - The current status depends on maintenance of existing support programs
 - Rural health care services are interdependent. Instability may be introduced by financing crises in other services (eg long-term care)
- Long-term trends are very troubling
 - Fewer providers going into Primary Care
 - Closure of Rural Residency Programs in other states

Assessing Access for Existing Patients: Benchmarks for Primary Care Physician Staffing Ratios

- Ideal staffing ratios if everyone insured/ability to pay
 - Studies of staff-model Health Maintenance Organizations
 - Between 1200:1 FTE to 1800:1 FTE
- Typical range with “normal” demand for total population
 - Urban/Large Town areas
 - General Population 1500:1 to 2000:1
 - Medicare Population: 1000:1 to 1400:1
- Significant stress
 - General Population 2000:1 +
 - Medicare Population 1500:1 to 2000:1
- Serious Shortage
 - HPSA criteria
 - General Population Over 3000:1
 - Medicare Population Over 2000:1
- Not an exact science
- Specialty Care ????????

Access for Existing Low-Income and Medicare Population is not as bad as we think, but...



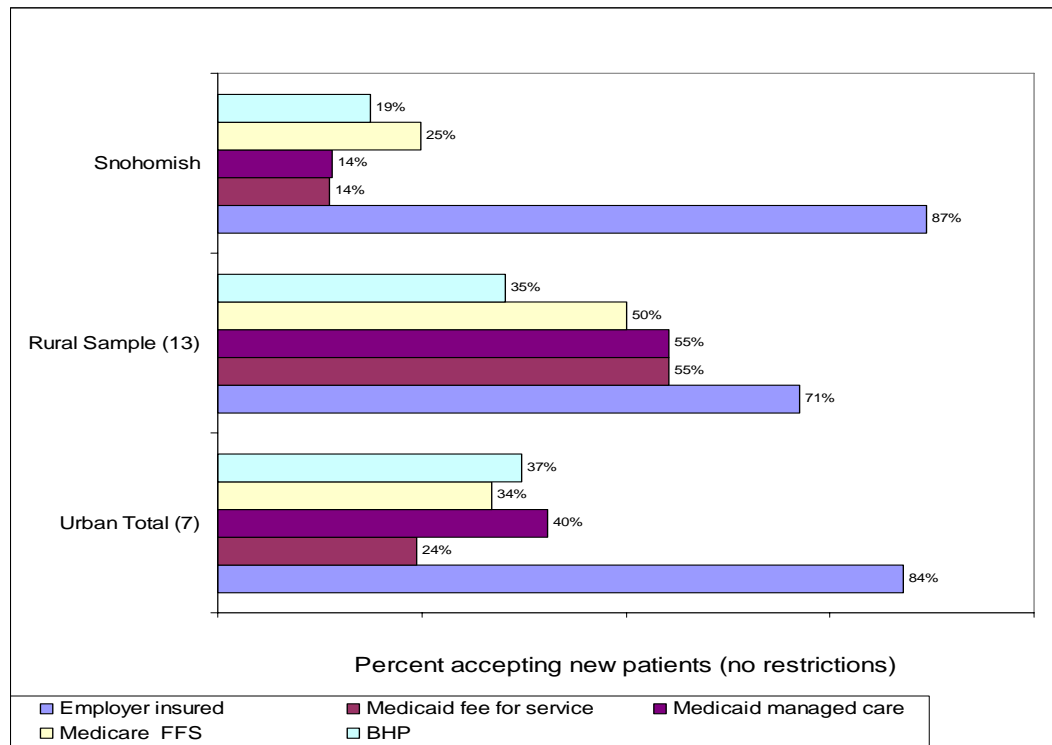
•Low Income

- Urban and Large Town Fairly Similar – Small Rural generally worse
- Access in Urban and Large Town Areas similar in a few cases better than access for the general population

•Medicare

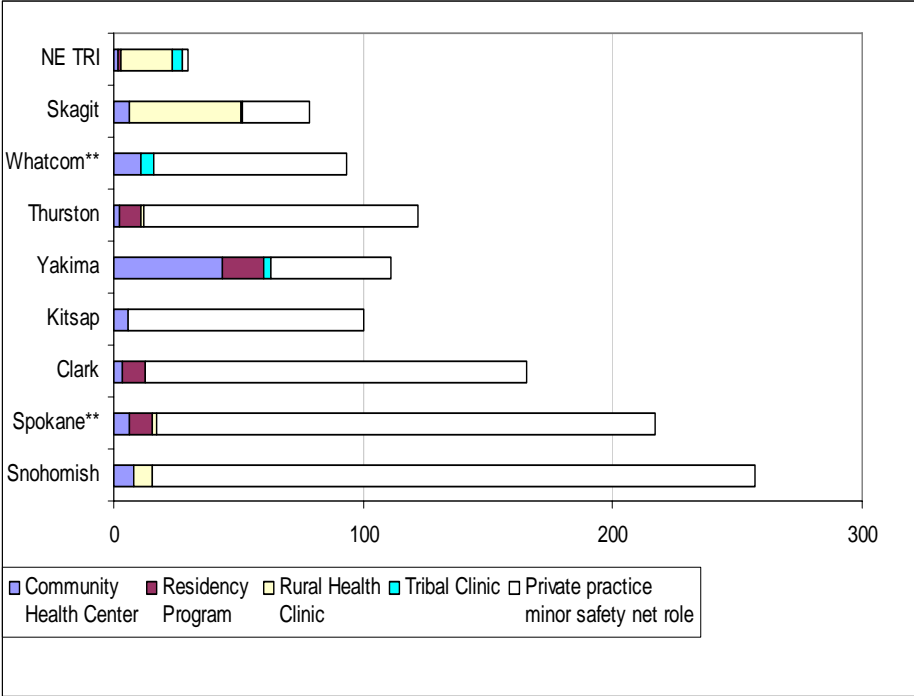
- In ideal to normal range most counties
- Better access in urban counties and rural counties with high RHC penetration

Access for New Public Patients in Snohomish County Among the Poorest Among Counties Which Have Been Surveyed in the past two years.

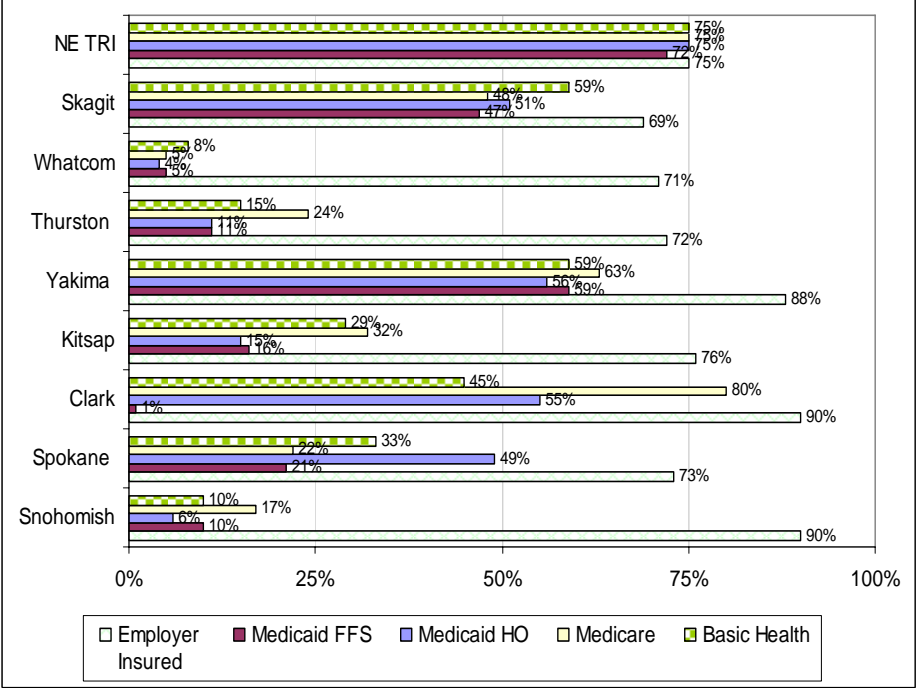


Comparison of Safety Net Characteristics and Whether Private Practices are Accepting New Patients

Primary Care Physician FTE by Clinic Type



% private practices/RHCs accepting patients without restriction



Health Care Access Research

- <http://www.doh.wa.gov/hsqa/ocrh/har/hcresrch.htm>
- Detailed county access reports on access to primary care
- Washington Rural Health Assessment Project
 - 7 short studies on primary care access – Elder Care – Children, Maternal Health etc (more planned – resources permitting)
- Washington Primary Care Safety Net Assessment
 - Overview of the system
 - Where to target resources
 - Past and future growth trends
- Healthcare Infrastructure Mapping Project
 - Mapping key features of the health care system in relation to population and travel
 - Maps include:
 - Hospitals, Rural Health Clinics, Community Health Centers, Rural Primary Care Clinics, Eldercare Options, and OB Access
- What is rural in Washington (and how it affects program availability)



Appendix

Other Services Available from the Office of Community and Rural Health

Office of Community and Rural Health: Other Services

- Recruitment and Retention Services
 - Washington Recruitment Group
 - State Loan Repayment Program
 - J-1 Visa Waiver
 - Area Health Education Center (AHEC)
 - Locum Tenens
 - Retired Provider Malpractice Insurance Program
 - Student programs (R/UOP, R/UOE, U-DOC, Ambassador Program)
- Primary Care Office
 - Community and Migrant Health Center development
 - National Health Service Corps site development

Other Services (Cont.)

- Rural Health Systems Development Grants
- Critical Access Hospital Program
- State-wide Office of Rural Health
 - Policy work and coordination
- Rural Health Clinic Program
 - Pre-qualification
 - Technical assistance (in process)



Contact Information

Vince Schueler

Office of Community and Rural Health

PO Box 47834

Olympia, WA 98504-7834

(360) 236-2806 (Voice)

(360) 664-9273 (Fax)

vince.schueler@doh.wa.gov

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